: 4165-15-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Proposed Collection: Public Comment Request; Maternal and Child Health Bureau Performance Measures for Discretionary Grant Information System (DGIS), OMB No. 0915-0298 - Revision

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, HRSA has submitted an Information Collection Request (ICR) to the Office of Management and Budget (OMB) for review and approval. Comments submitted during the first public review of this ICR will be provided to OMB. OMB will accept further comments from the public during the review and approval period. OMB may act on HRSA's ICR only after the 30-day comment period for this Notice has closed.

DATES: Comments on this ICR should be received no later than **[INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE *FEDERAL REGISTER*].**

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to www.reginfo.gov/public/do/PRAMain. Find this particular information collection by selecting "Currently under Review - Open for Public Comments" or by using the search function.

FOR FURTHER INFORMATION CONTACT: To request a copy of the clearance requests submitted to OMB for review, email Samantha Miller, the acting HRSA Information Collection Clearance Officer at paperwork@hrsa.gov or call (301) 443-9094.

SUPPLEMENTARY INFORMATION:

Information Collection Request Title: Maternal and Child Health Bureau (MCHB) Performance Measures for Discretionary Grant Information System (DGIS), OMB No. 0915-0298 – Revision

Abstract: Approval from OMB is sought to implement minor revisions to the MCHB Performance Measures for DGIS. Most of these measures are specific to certain types of programs and are not required of all grantees. The measures are categorized by domain (Adolescent Health, Capacity Building, Child Health, Children with Special Health Care Needs, Lifecourse/Crosscutting, Maternal/Women Health, and Perinatal/Infant Health), in addition to some program-specific measures. Grant programs are assigned domains based on their activities and individual grantees respond to only a limited number of performance measures that are relevant to their specific program.

HRSA intends to change the numbering sequence of the DGIS forms in an approach different from what was outlined in the *Federal Register* notice (87 FR 3313) published on January 21, 2022. The approach outlined in the January 21, 2022, notice provided for the re-use of form numbers by reordering the form sequence to accommodate the forms being removed and added. After further consideration, HRSA intends to retire the number associated with the six DGIS forms being removed and give the new DGIS Training form the next number in the numbering sequence (Training Form 15, which was previously labeled as Training Form 14 in the January 21, 2022, notice). This streamlined approach will prevent confusion among grantees and HRSA when referencing the forms after they are updated in DGIS.

No additional forms are proposed to be added, removed, or revised beyond what was specified in the January 21, 2022, notice. As noted in the January 21, 2022, notice, HRSA is making the following changes to the current information collection for MCHB DGIS to more closely align data collection forms with the program activities:

Removing the following existing forms: Core 1 (Grant Impact), Capacity Building 2 (Technical Assistance), Capacity Building 7 (Direct Annual Access to MCH Data), Training

Form 13 (Diverse Adolescent Involvement (Leadership Education in Adolescent Health Program –specific)), Financial Form 2 (Project Funding Profile), and Financial Form 4 (Project Budget and Expenditures);

Adding the following new forms: Training Form 15 (Consultation and Training for Mental and Behavioral Health) and Leadership, Education, and Advancement in Undergraduate Pathways Training Program Trainee Information Form. The title of Training Form 15 was changed from "Teleconsultation" to "Consultation" to acknowledge that some programs that report on this form may also have an in-person consultation component. Therefore, the form was updated to capture both teleconsults and in-person consults and the title was adjusted to represent this change;

Revising the following existing forms: F2F (Family to Family Form 1), Financial Form 1 (MCHB Project Budget Details), Financial Form 4 (new name: Maternal & Child Health Discretionary Grant Project Abstract), MCH Training Program Data Forms, Core 3 (Health Equity), Financial Form 3 (Budget Details by Types of Individuals Served), Financial Form 5 (Number of Individuals Served (Unduplicated)), and Financial Form 6 (Project Abstract); and

Moving the following form to a new category: Core 2 (Quality Improvement) will become Capacity Building 8 (Quality Improvement). Moving this form out of the Core category and into the Capacity Building category will allow HRSA to assign this form to only applicable grantees. Note that in the January 21, 2022, notice, Core 2 was proposed to become Capacity Building 4, however, due to the decision to change the numbering sequence in the DGIS, the form will now use the next number in the numbering sequence (following Capacity Building 7).

Non-substantive revisions also include updates to terminology, goals, benchmark data sources, and significance sections included in the measures' detail sheets. A performance measure detail sheet defines and describes each performance measure. Forms and detail sheets showing the proposed revisions are available upon request.

In response to the notice published on January 21, 2022, HRSA received six requests to

view the proposed revisions and six public comments. One comment, with which the Department agrees, conveyed support for the proposed DGIS form updates and relayed that it will improve their organization's ability to understand trainees with relation to gender diversity and decrease the burden of completing DGIS reporting. Another comment also conveyed support for removing several forms to alleviate reporting burden, with which the Department agrees. In addition, this same commenter supported the proposal to align the age ranges across DGIS measures, specifically between Form 5 and Form 3, with which the Department also agrees. This commenter also relayed concern over the administrative burden required to count and report specialty providers by specialty type for trainings and requested clearer guidance for how to accurately count provider types in Training Form 15 (referenced as Training Form 14 in the January 21, 2022, notice). Finally, the commenter relayed concern that requiring providers to submit data to HRSA (for purposes of Training Form 15) could preclude providers from participating in the program given their limited resources. The Department appreciates the challenges of providers reporting data; however, this information is critical for HRSA to be able to track program impact.

Similar comments regarding count of providers by specialty type were received by a third commenter, with a focus on the difficulty to collect this data related to depression training and additional burden that is created when the count is required to be de-duplicated by provider type. The Department acknowledges counting and reporting specialty providers by specialty type requires more effort than counting and reporting providers without specialty type. However, provider specialty type is crucial to HRSA's ability to measure programmatic reach and impact, which is used to inform programmatic and policy decision making. To provide better guidance, the form has been updated to include "non-specialty" to the applicable sections of the tables to assist with reporting and the Department will ensure Training Form 15 is programmed into DGIS in such a way that it is clearer to the grantee that any provider type not listed should be counted in an "Other" category. Additionally, grantees are not expected to de-duplicate training counts

by provider type. If grantees do not have information on the type of providers who attended a training, it is acceptable to place counts under "Other."

Additional comments received by a fourth commenter on Training Form 15 included feedback regarding the difficulty for their teleconsultation line staff to track and report the number of enrolled providers who may be eligible to call the line; the need for clarification on how a care coordinator/patient navigator is defined; the need for clarification on what "teleconsultation" specifically entails and what level of provider needs to provide this service; the need for clarification around specific terms, including: polysubstance use, disruptive, impulse-control, conduct disorders as well as co-occurring mental and substance use disorders; a request for HRSA to make the individuals served screening-level measure optional for Maternal Depression and Related Behavioral Disorders (MDRBD) grantees similar to Pediatric Mental Health Care Access program (PMHCA) grantees; feedback that depending on the specific modality used to obtain practice-level screening data, the numerator and denominator time frame may not fully align with the federal fiscal year; and a request for clarification regarding reporting the number of referrals given with a suggestion that HRSA define this measure not as the number of referrals provided, but rather as the number of referrals services/supports that could be offered.

In response to these comments, the Department has made the following updates to Training Form 15: "if applicable" has been added in the first table requesting the number of providers enrolled AND participating; consultation language has been clarified by changing "teleconsultation" to "consultation," which includes both teleconsultation and in-person consultation. If a call/contact includes both consultation and care coordination support the contact should be reported in the "Both" category; polysubstance use and co-occurring mental and substance use disorders have been removed from the list of condition(s) to report why providers contact the program for consultation; and the individuals served screening-level measure now reflects as optional for MDRBD grantees similar to PMHCA grantees.

The Department wishes to clarify that family visitors and doulas should be reported as Care Coordinators/Patient Navigators if that is the role they are filling and reporting the number of referrals given is solely for referral and treatment recommendations for providers who contact the program. Grantees should be able to collect this information at the time the provider contacts the program and no updates have been made to the form regarding this question.

This commenter also provided feedback on the Core Health Equity Form, Women and Maternal Health (WMH) 1, 2, and 4, and Financial Forms 2, 3, and 5 (now Financial Forms 3, 5, and 7). While the commenter welcomes the revisions of the Core Health Equity form, they clarified that specific health equity goals and objectives being pursued may be overarching and aligned with organizational equity aims, and as such, progress toward achieving them may be hard to quantify and/or specify from a programmatic-level.

The Department recognizes there may be some overlap with larger organizational aims, however, health equity is a focus of MCHB programs and it is necessary to capture how grantees are advancing health equity. With regards to WMH 1 and 2, the commenter provided feedback that it remains difficult to specify/stratify training counts specific to pregnancy and postpartum care given that most training is specific to the perinatal period. As a result, grantees whose focus spans the entirety of the perinatal period like MDRBD grantees would benefit from additional reporting instruction on how best to fill out these forms and whether to include training counts only in Training Form 15 or in WMH 1 and 2 forms as well. The Department recognizes that some programs may span pregnancy and postpartum periods, however, there is a need to capture prenatal care (WMH 1) in the first trimester and timely postpartum visit (WMH 2) separately to demonstrate each of these measures are improving.

The Department wishes to clarify that for programs with trainings that may cover pregnancy and post-partum care, these trainings should be counted under both WMH 1 and WMH2. These trainings however should include content on timely prenatal and timely postpartum care.

Finally, the commenter requested HRSA consider making the Tier 4 measure for WMH 4 optional given reporting difficulty and the amount of time it would take to enact needed electronic medical record modifications and reporting protocols to obtain treatment/referral information; any immediate information provided in this area would require manual tracking. After further consideration, the Tier 4 measure for WMH 4 has been updated to reflect its optional status, bringing it into alignment with the updates made to Training Form 15. Additional comments received by a final commenter on Training Form 15 included requested clarification on the definition of "enrolled provider," guidance for how to classify the reason for provider contact, requested clarification on how to count the number and types of providers trained, an example for what constitutes "treatment strategies," and a specific definition for the term "treatment."

As a result of this feedback, the form has been updated to include a footnote which clarifies that an "Enrolled" provider is one who is currently enrolled in the program even if initial enrollment occurred prior to the current reporting period. With regards to classifying the reason for a provider contact, the Department clarifies that the intent is to not limit responses to specific diagnoses for this question. If a specific diagnosis can be captured at the time of the call, it should be captured as such. If it cannot, and the reason(s) for the call are not included in the provided list, the grantee should capture the reason for the call under the response option titled, "Other (please specify)." In addition, the form has been updated to state "Treatment modality-focused trainings" instead of "Treatment strategies-related trainings." Finally, recognizing each grantee may define "Treatment" differently, the Department clarifies that "Treatment" is broadly defined for both PMHCA and MDRBD programs as, "the provision, coordination, or management of health care and related services among health care providers."

Two additional commenters provided feedback on the Family-to-Family (F2F) Form 1. The first commenter provided the following: a recommendation that parents of children and youth with special health care needs be specified in the definition of the numerator as they are in

other related statements in the document; concern about the removal of the details "family centered, comprehensive, and coordinated system" in the benchmark data sources replaced with "a system of care," with a recommendation of listing additional other benchmarks here, such as Healthy People 2030 MICH-19; language that states F2F services are either one-to-one or through group training and events, with a recommendation to replace "one-to-one" with "individual total number of families receiving one-to-one services (including small group individualized assistance); use of a Likert scale when capturing the percentage of one-to-one services and trainings provided by topic, as well as when capturing the percentage of services and trainings to professionals/providers provided by topic; use of the term "American Indian or Alaska Native" instead of "tribal organization;" and concern about the removal of four subcategories that were previously used to report the types of services/trainings provided to families, and removal of references to the six core outcomes in the form.

After considering the feedback, the measure's numerator has been revised to state: "The total number of families of children and youth with special health care needs receiving one-to-one services and training from Family-To-Family Health Information Centers." This revision reflects how MCHB tracks and reports program impact.

Question 1 has been revised to include the phrase, "small group individualized assistance." After considering the commenter's use of Likert scales when capturing the percentage of one-to-one services and trainings provided by topic, as well as when capturing the percentage of services and trainings to professionals/providers provided by topic, these questions have been removed from the form. After further consideration, the four subcategories that were previously used to report the types of services/trainings provided to families has been added back to the form. Finally, the form has been updated to reflect "American Indian or Alaska Native" instead of "tribal organization." This revision aligns all of the selections in table 2c of the F2F form to be population focused and not a mix of populations and organization.

With regards to the use of MICH-19 in addition to the benchmark data source of MICH-20, the Department intends to proceed with the use of MICH-20, as "systems of care" includes having a medical home. While the title of the objective has changed, the objective of receiving care in a system of care is still the same. Finally, with regards to the removal of references to the six core outcomes in the form: Despite removal from the form, the six core outcomes remain foundational for all work to improve systems of care. The Department intends to proceed with removal and would like to reiterate that grantees can report on the six core outcomes in their annual progress report.

The second commenter on the F2F form mirrored those of the first and no additional consideration was necessary.

Need and Proposed Use of the Information: The performance data collected through the DGIS serves several purposes, including grantee monitoring, program planning, performance reporting, and the ability to demonstrate alignment between MCHB discretionary programs and the Title V MCH Services Block Grant program. This revision will facilitate more efficient and accurate reporting of information related to Capacity Building activities, Financial and Demographic data, and Training activities.

Likely Respondents: The grantees for Maternal and Child Health Bureau Discretionary Grant Programs.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install, and utilize technology and systems for the purpose of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the

collection of information; and to transmit or otherwise disclose the information. The total annual burden hours estimated for this ICR are summarized in the table below.

Total Estimated Annualized Burden - Hours

Form	Number of Respondents	Responses per Respondent	Total Responses	Burden hours per response	Total burden hours
Grant Report	700	1	700	36	25,200

HRSA specifically requests comments on (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions, (2) the accuracy of the estimated burden, (3) ways to enhance the quality, utility, and clarity of the information to be collected, and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Maria G. Button,

Director, Executive Secretariat.

[FR Doc. 2022-12391 Filed: 6/8/2022 8:45 am; Publication Date: 6/9/2022]